WV Health Innovation Collaborative
Better Health & Better Care Work Groups
Meeting Notes
April 5, 2016

Present:
Nancy Sullivan, DHHR, Chair, Better Care Work Group
Leslie Cottrell, WVU, Co-Chair, Better Value Work Group
Anne Williams, DHHR, Bureau for Public Health, Co-Chair, Better Value Work Group
Melanie Riley, WV Perinatal Partnership
Shauna Lively, WV Perinatal Partnership
Christina Mullins, DHHR, Bureau for Public Health, Office of Maternal, Child and Family Health
Sanjay Mitra, WVU School of Medicine – Panel Member
Panitan Yossuck, WVU School of Medicine – Panel Member
Laura Lander, WVU School of Medicine/Chestnut Ridge Center – Panel Member
Sean Loudin, Marshall Health, Cabell Huntington Hospital, Lily's Place – Panel Member
Rhonda Edmunds, Lily's Place – Panel Member
Pat Kelly, WV Health Care Association
Kathy Cummons, DHHR, Bureau for Public Health, Office of Maternal, Child and Family Health – Newborn Screening
Bruce Adkins, DHHR, Bureau for Public Health, Office of Community Health Services and Health Promotion
Barbara Wessels, UniCare
Tina Ramirez, Kanawha-Charleston Health Department
Amy Hoyer, Kanawha-Charleston Health Department
Ciara Moore, Kanawha-Charleston Health Department
Sharon Carte, WV Children's Health Insurance Program
Crystal Welch, WV Medical Institute
Christine DeRienzo, PEIA
Debbie Waller, DHHR

By Phone:
Lillie Clay, DHHR, Bureau for Medical Services
Tameran Asbury, Drug Free Mother Baby Program – Panel Member
Tracy Dlott, WVU, Health Sciences Center
Tony DiChiacchio, WVU, Health Sciences Center
Dan Christy, DHHR, Bureau for Public Health
Michelle Chappell, American Cancer Society
James Becker, DHHR, Bureau for Medical Services/Marshall University
Molly McMillian, WV Perinatal Partnership
Anduwyn Williams, WV FREE
April Vestal, WVU, Health Sciences Center

Julie Palas, Catastrophic Illness Commission/Women's Commission
Carrie Brainard, Wirt County Health Department

Nancy Sullivan opened the meeting and welcomed everyone in attendance. Self-introductions were made. She introduced Leslie Cottrell, Co-Chair of the Better Health Work Group who will be facilitating the meeting.

Dr. Cottrell shared with the group a brief background. For several months, the Better Health and Better Care Work Groups have been looking at certain areas of the State Health Improvement Plan. Neonatal Abstinence Syndrome (NAS) is listed in that document as a target area. The work groups have been working on the substance abuse issue but now want to break it down and work on NAS. Each panel member has done a lot of work in this area.

The chairs of the work groups came up with a few questions for the panel members.

- Throughout the literature, there are differences even in the definition of NAS. Do we have a finalized definition throughout our state? U.S.? If not, what is needed to get there?
- To what extent does NAS impact WV babies? What is the prevalence? Are our current approaches to assessing the prevalence what they need to be? Explain.
- Once identified, what treatments do NAS babies generally receive? Is there great variability across sites for this? Are you as providers limited in some ways for providing other services? Please explain.

Each panel member shared their experiences with NAS, issues, barriers, etc.

Definition of NAS: Dr. Loudin: As part of the Perinatal Partnership, delivering this definition to all the hospitals in the state. Distribute to all physicians, pediatricians, nurses, coders, etc. to make sure everyone is on the same page.
Definition: NAS will be diagnosed when an infant has been exposed to any neuroactive substance in utero and then exhibits symptoms consistent with withdrawal, regardless of whether or not there was a need for pharmacological interventions to treat the infant's withdrawal.

What We Learned:

- Birth hospitals do not have a lot of feedback or resources for identifying NAS. Those who are attending the training sessions are not the people who will be diagnosing. We need to identify strategies for not only keeping the trained individuals involved with continued education but incorporating others from the practice.

-Could compare NAS outcomes based on those who have attended the trainings or other opportunities to those who haven't.

- Additional data analyses is needed to fully understand practice discrepancies and training gaps.
- Reporting varies greatly across sites: exposure and incidence would be the two of value to consistently report.
- Attention is needed to identify treatment options for mothers using substances – limited in number and long wait lists.
- OB's are often placed in the precarious position of prescribing medications that would help with withdrawal symptoms and reduce use during pregnancy but masking symptoms with other drugs; need to align with goals of community (abstinence vs. maintenance).
- Surveillance systems are needed to gauge statewide issue.
- Current health care model focused on dollars as incentives, fuels the number of hospitals who base treatment for NAS with shortened length of stay times.
- Need to broaden scope of health care facilities to broaden reach for treatment/reimbursement.
- There is a perception that mothers who are in active CPS cases are not eligible for programs that would improve bonding (in-home services, etc.).
- Need to focus on lengthening interconception period.

Next Steps:

- Consider role for telemedicine to provide services to mothers before birth of baby (but also at any point as well as provider training).
- Compare data based on drug type used by mother and subsequent treatment and health outcomes.
- Consider mandating report of exposure and incidence across practice.
- Consider center for comprehensive treatment for mothers.
- Develop guidelines for practitioners on best practices for treating mothers outside of the substance use clinics when access to specialty services are limited.
- Identify and implement screening approach (Office of Maternal, Child, and Family Health plan).
- Develop alternative model that is based on tailoring treatment to baby's needs rather than incentives for shorter length of stay.
- Allow NAS centers to be recognized as health care facilities.
- Mothers who are in active CPS cases are eligible for programs – provide education and media to correct perceptions and practices.
- Develop models where contraception could be provided in alternative settings (e.g., Methadone clinics) related to other services.

Dr. Cottrell expressed appreciation to all the panel members for taking the time to share all their experiences with the members.

Ms. Sullivan shared with the group that the WVHIC Quarterly meeting is Monday, April 11 at 1:30 p.m. The National Governors Association will be visiting. We will be discussing the Patients with Complex Care Needs Initiative – Super Utilizers. We will be targeting ER usage. The meeting will be at One Davis Square in Conference Room 134.